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May 3, 1995

Anne K. Bingaman, Assistant Attorney General
Antitrust Division
United States Department of Justice
10th and Constitution Avenue N.W. - Room 3109
Washington, D.C. 20530

Re: Expedited Business Review Approval Request
RWHC Network, Inc.

Dear Ms. Bingaman:

Pursuant to the Department of Justice's Expedited Business Review Procedure announced on December 1, 1992 (59 Fed. Reg. 6132 (1993)), our law firm is requesting the Department's review of a proposed Wisconsin nonprofit corporation's anticipated activities in the area of health care. The proposed nonprofit corporation will be named RWHC Network, Inc. ("Network"). This request is made pursuant to the Expedited Review Procedure and 28 CFR § 50.6. Our request is made upon the basis of the best information known to date and upon reasonable estimates of future activity. Where possible, the proposed entity will implement any suggested modifications which address any antitrust concerns of the Department.

The activities of Network would be for the purpose of facilitating the association of certain rural hospital providers for marketing, contracting, and educational purposes.

We verify that this Expedited Business Review procedure has been invoked in good faith and we have made a diligent search for documents and information required to be submitted pursuant to 28 CFR § 50.6 and, where possible, have provided complete disclosure of all responsive material.

1. Name; Address.

The name of the proposed entity is RWHC Network, Inc. ("Network"). The principal place of business will be: c/o Rural Wisconsin Health Cooperative, 724 Water Street, Sauk City, Wisconsin. The proposed entity will be a Wisconsin, nonstock, nonprofit corporation organized under the Wisconsin Nonstock Corporation law (Chapter 181 Wisconsin Statutes, 1994). There would be no shareholders of the corporation. However, as permitted by the Wisconsin Nonstock Corporation law, there would be corporate

members. No dividends or profits would be distributed to members. There would be a single member classification. Membership in the Network would be limited to the rural hospitals that own and operate the cooperative. Membership in the Network would not be a requirement of participation in the Cooperative. It is possible, and in fact probable, that not every rural hospital eligible to participate in the Network will participate in the Network. Thus, the rural hospitals that own and operate the Cooperative constitute the largest number of possible participants. While the University of Wisconsin Hospital & Clinics is a member of RWHC, it will not be eligible for this project.

2. Persons Expected to Participate.

Persons eligible to participate would, as noted, be those rural hospitals that own and operate the Cooperative. These are all 501(c)(3) nonprofit hospitals. Such hospitals are small, rural hospitals which provide inpatient and outpatient care of a nontertiary nature, services which tend to have a hospital primary care DRG code. A list of the rural hospitals that own and operate the Cooperative, their geographic location and bed size is as follows:

Rural Hospitals	Location	Bed Size
St. Clare Hospital & Health Services	Baraboo	78
Black River Memorial Hospital	Black River Falls	36
Boscobel Area Health Care	Boscobel	44
Columbus Community Hospital	Columbus	53
Memorial Hospital Of Lafayette Co.	Darlington	28
Memorial Hospital Of Iowa Co.	Dodgeville	39
Memorial Community Hospital	Edgerton	40
Adams County Memorial Hospital	Friendship	40
St. Joseph's Memorial Hospital & Home	Hillsboro	20
Lancaster Memorial Hospital	Lancaster	31
Mile Bluff Medical Center	Mauston	22
Myrtle Worth Medical Center	Menomonie	55
Memorial Medical Center	Neillsville	40
Southwest Health Center	Platteville	8
Prairie Du Chien Memorial Hospital	Prairie Du Chien	45
Sauk Prairie Memorial Hospital	Prairie Du Sac	36
Reedsburg Area Medical Center	Reedsburg	22
The Richland Hospital	Richland Center	41
Ripon Memorial Hospital	Ripon	29
Stoughton Hospital	Stoughton	41
Vernon Memorial Hospital	Viroqua	23

3. Objectives of the Venture.

This venture will not require exclusivity and at this point does not include physician services.

The objectives of the proposed venture would be as follows:

A. To assist smaller, rural hospitals to contract fairly with parties which are substantially more sophisticated in managed care contracting.

B. An important motivation for this project is to protect the competitive viability of smaller, rural hospitals, which is crucial to the continued existence of local control of public health decisions and important to local economies. RWHC members are, with one exception, governed at the local community level.

C. To create a health care provider organization with a substantial emphasis on primary hospital care. The term "primary hospital care" means services typically found in smaller, rural hospitals and covered by a primary care DRG code, general family practice, general practice, general internal medicine, as well as certain surgical procedures and general pediatrics.

D. To facilitate contracting or subcontracting between rural hospital members and other entities such as insurance companies, employers, and other groups for the furnishing of hospital health care services. Network would, with the assistance of a Third Party Administrator, negotiate with these organizations for the furnishing of hospital health care services.

E. Network would actively seek to protect the rights of patients to choose their own hospitals and physicians.

F. Network would assist hospitals and physicians to resist being unfairly eliminated or locked out of health care markets by other competitors.

G. Network would assist hospitals in furnishing high quality, cost effective and competitive hospital health services within the state of Wisconsin. This would be accomplished, as the mission of Network evolves through the services of a Third Party Administrator, a utilization management committee, a quality management committee and a credentials committee, or other appropriate mechanisms.

H. Network would offer a mechanism for member hospitals to act as partners in creating structures responsive to managed care and providing for risk sharing as appropriate.

I. Network would offer the opportunity for hospitals to interact directly with businesses and employers to offer "bundled" sets of medical and surgical services on a regional basis under a simplified and unified billing arrangement. Network would enable rural hospitals, which are otherwise at a distinct disadvantage in the evolving managed care market, to deal directly, constructively and efficiently with managed care entities.

J. Network would not require an exclusive relationship of its members. Participating hospitals could choose to be part of some or all of Network's activities on a year-by-year basis. At the same time, they would have complete freedom to enter into contracts with managed care entities or others independent of Network.

K. Initially, the focus of Network's activities would be on assisting member hospitals in relation to contracting with Third Party Payors, marketing, and educational endeavors. Eventually, Network would hope to participate in the negotiation of a global capitation rate approach with insured entities regulated by the Wisconsin Office of the Commissioner of Insurance.

4. Products or Services.

Network would not itself furnish products or services. It would assist rural hospitals to furnish high quality, cost effective and competitive hospital health services in the state of Wisconsin. The services would be provided directly by member hospitals through contracts with Third Party Payors, or through contracts with Network. Initially, services are expected to be provided on a discounted fee-for-service basis although eventually, as noted, it would be the goal of Network to consider a capitated fee structure which would enhance cost effective competition in the rural hospital health care marketplace. It is possible, although not currently planned that in the future individual members of Network could decide to examine on a case-by-case basis such additional integration as would be appropriate in the circumstances of the individual hospitals and the marketplace.

5. Extent to Which Members in Network Currently Market Services.

Each prospective member of Network presently negotiates its own individual contracts with insurance companies, employers and

other organizations. Upon implementation of Network, at the election of the individual hospital, contracting would be done by Network with the assistance of a Third Party Administrator such as the Rural Wisconsin Health Cooperative ("RWHC"). This would allow greater efficiency and reduce repetitive contract discussions with multiple parties. Members of Network will not have to spend considerable time in negotiating contracts individually and not have to spend resources having such contracts analyzed by attorneys. This will, in turn, allow health care providers to devote more time to delivery of health care. This approach will presumably simplify matters for consumers and Third Party Payors.

6. The Identity and Competitive Significance of Persons Who Participate in the Relevant Product and Geographical Market.

Our analysis of state data shows clearly that RWHC hospitals compete not with each other but with outmigration. Each hospital has a clearly defined market with minimal overlap with its immediate neighbors. If people do not choose to receive care locally, they go into a regional center, not another RWHC rural hospital. This data reaffirms the long standing impression of rural hospitals and physicians in southern and central Wisconsin. (See Attachment 1)

7. Restrictions on Ability of Participants to Compete With the Venture.

As noted, the Network will be nonexclusive and there will be no limitation on the ability of any member to join other organizations or other competing entities. The venture would be more than willing to incorporate in its documentation language such as the following:

> "Application or approval for membership in the corporation shall not prevent any member from participating in any preferred provider organization, physician-hospital organization, organized delivery system, independent practice association, or other health care provider organization, or any other contractual relationship in addition to the corporation."

A model Provider Agreement, attached hereto as Attachment 2, provides at 11.3 as follows:

> "Provider retains the right to contract independently with Third Party Payors."

8. Restrictions on the Flow of Information From the Venture to Its Members.

Rural hospitals which own and operate RWHC are extremely sensitive to questions of information flow. They have taken a very conservative position and although they do not believe they are competitors, they have adopted mechanisms to regulate and aggregate information which might be problematic if such information were shared between competitors. This sensitivity would continue with respect to Network. Network and its members would be more than willing to adopt language requiring Network to retain a Third Party Administrator (TPA) such as RWHC to create data bases, prepare statistical analyses, and furnish recommendations to enable Network to negotiate contracts for health care and to help carry out the purposes for which the corporation is formed, all consistent with the antitrust laws and other applicable federal and state laws. It would be anticipated that all such information obtained by the TPA would be proprietary and confidential. Network could require, as a condition of membership, that each member would covenant and agree that, except for the final statistical analysis and recommendations of the TPA, no member would have access to any disaggregated information held by the TPA or any accounting firm, actuary or research firms providing services to the TPA.

Network would be pleased to adopt language ensuring that no member would have access to another member's patient fee or pricing information or other financing information including, but not limited to, salary and fringe benefits for associates or employees or gathered by a Third Party Administrator as appropriate except as may be consistent with the antitrust laws.

For your information and as additional background for this letter, RWHC was initiated in 1979 by several hospital administrators in southern and central Wisconsin as a shared service corporation and advocate for rural health. The Cooperative was the major force behind the formation in 1983 of a then non-stock, not-for-profit insurance corporation, HMO of Wisconsin which was sold in 1994 to United Wisconsin Services Inc. (a Blue Cross subsidiary).

In 1984, Mobile CT and Nuclear Medicine services were initiated through the development of private sector partnerships and the Cooperative became active nationally as a vocal advocate for Medicare payment equity. The Cooperative was recognized for its work the following year by both the Wisconsin legislature and the National Rural Health Association. In 1987, major grant awards were received from the Robert Wood Johnson and W. K. Kellogg Foundations. In 1990, the Cooperative played a significant role in

the initiation of Wisconsin's Rural Health Development Council and its Rural Medical Center initiative. In 1992, two Cooperative hospitals joined pilot sites in New York, Philadelphia and Phoenix to implement the Hospital Research and Education Trust's Community Health Intervention Project.

Today over 150 Cooperative staff or contracted professionals provide services directly in areas such as: advocacy, audiology, multi-hospital benchmarking and other quality improvement initiatives, grantsmanship, occupational therapy, per diem nursing, physical therapy, respiratory therapy, physician credentialing, speech pathology, emergency room physician staffing and ongoing rural specific continuing educational opportunities. The Cooperative has negotiated special group contract arrangements for members to obtain high quality consultant services in areas such as: legal services, personnel consulting, market research, patient discharge studies and consultant pathology services.

The Cooperative is governed by a Board of Directors consisting of one representative (usually the hospital administrator) from each Cooperative hospital, each with one vote on the Board of Directors. While a consensus is usually sought, it is not required. An Executive Committee is empowered to act on behalf of the Board between regular meetings and performs the functions of planning and personnel committees. A Finance Committee is responsible for setting and evaluating financial goals and performance. Ad-hoc Committees are created as needed for specific time-limited functions.

Cooperative directors have two distinct roles in decision-making related to Cooperative activities. As a director of the Cooperative, decisions are expected from the perspective of what is best for the Cooperative. As a hospital administrator, decisions about participation in a the Cooperative program are made from the hospital's individual perspective that includes the judgment of the hospital board, medical staff and other local parties. Services provided to the Cooperative hospitals are based on written contracts between each participating hospital and the Cooperative. Apart from limitations within some of these contracts, the Cooperative hospitals are not required to buy services solely through the Cooperative.

Wisconsin has a high concentration of multi-group specialty clinics that have been aggressively investing in the vertical control of physician practices in smaller communities, primarily through their outright purchase. The Cooperative has a strategic alliance with the Community Physicians Network in order to support community based practice. Short-term initiatives currently

underway include (1) the development of a pool of administrative specialists who will work on site with local practices to reduce expenses, improve reimbursement and other services to improve physicians' ability to be successful in a managed care environment; (2) the identification and coordination of linkages that will enable providers to meet the needs of their patient population, (3) the provision of shared services such as per diem support clinic staff and locum tenens coverage and (4) the securing of access to malpractice insurance discounts typically available only to large group practices.

9. Ten Largest Customers (Projected) for Services to be Offered by the Venture.

Because this venture is still at a developmental stage, we cannot project with any precision or to identify the ten largest customers for services which would be offered by Network. We assume that such customers may be from among managed care entities with significant market share in the individual markets of Network members. These would include managed care entities and products from Madison (Physicians Plus HMO, DeanCareHMO, Unity--a product line of United Wisconsin Services), Marshfield, LaCrosse, Eau Claire, Milwaukee and Rochester, Minnesota. If requested, we would develop information regarding such payors in the individual markets served by members.

10. Requirements for Entry Into Any Relevant Product or Geographic Market and the Identity of Persons Believed to be Positioned to Enter Into the Market.

We do not believe that the rural hospitals which are potential members of Network significantly compete with each other with reference to the products which will be the subject of this venture. With reference to each rural hospital's geographic market and relevant product market, since this project involves nontertiary hospital services, there are significant requirements for entry into both a particular geographic market and product market. A party wishing to enter a particular geographic market would be required to establish a hospital licensed under Wisconsin law. There are significant barriers for one rural hospital competing in the geographic market of another rural hospital. All the rural hospitals involved in this discussion maintain quality services. The geographic markets for individual rural hospitals are the local communities which utilize and support the local hospital. The local hospital is generally an important economic component of the local economy and is integrally tied to the local community. There is little, if any, opportunity for product

differentiation on a quality basis which would motivate local consumers of health services to migrate to another market area.

There are, however, tertiary care institutions which could and do compete with individual rural hospitals throughout the contiguous markets constituting the aggregate geographic area served by rural hospitals. These include hospitals reflected on Exhibit 1 and are located in Madison, Eau Claire, LaCrosse, and Marshfield, among other places. These entities can compete with relevant products in the geographic area. There are minimal barriers for such institutions to do so.

11. Business Efficiencies That are Likely to Flow From the Venture.

Our hospitals are lower cost providers. This is affirmed by the Federal Government through its lower Medicare reimbursement to rural hospitals. Without the requested ability to negotiate collectively with large tertiary care driven regional systems, lower cost local providers are at high risk of being locked out of the market. This would leave only higher cost options.

There are business efficiencies that will flow from the venture. Hospitals will be able to save time and financial resources with respect to negotiation of managed care contracts. It is hoped that Network will provide a mechanism and motivating force for achieving other efficiencies with reference to billing, claims processing, utilization review, and other clinically related matters. These efficiencies represent a significant savings for the hospitals which may be passed on to managed care in an effort to have rural hospitals maintain a competitive position, vis a vis, competitive tertiary care institutions.

12. All Documents Reflecting the Formation of the Venture.

This project is still at a developmental stage. There is limited documentation reflecting the formation of the venture. Network has not yet been incorporated. Enclosed are documents reflecting current stage of development of Network. These include:

A. Analysis of RWHC internal and external competition marked as Attachment 1.

B. A draft Provider Agreement marked as Attachment 2.

C. A draft of model Bylaws for Network marked as Attachment 3. (Used for preliminary discussion purposes only)

13. Documents Concerning the Business Plans or Strategy for the Venture.

Please see 12 above.

14. Documents Prepared Within Two Years Reflecting the Business Plans of Any Venture Participant.

Because this project is still at a developmental stage, we do not have documents reflecting the business plans of any potential venture participant relating to the venture. We are assuming that 14 does not apply to internal business plans of any potential participant. We are not in possession of such documents.

15. Documents Discussing or Relating to Legality or Illegality Under the Antitrust Laws of the Venture or Competition or the Price of any Product or Service.

We have considered legal questions relating to the antitrust laws for this particular venture. However, in order to proceed most efficiently, and to minimize costs, there have been no opinions rendered with respect to the project. The material under question 12 reflects the documentation on this matter.

16. Documents Showing the Person or Firms Expected to Exchange Information.

See 12 above. See question 8.

17. The Purpose and Objectives of the Information Exchange.

The purpose and objectives of any information exchange would be to create appropriate data bases, prepare a statistical analysis, and furnish recommendations to enable Network to negotiate contracts for hospital health care services and the help to carry out the purposes for which Network was formed. Such information gathering and analysis would be provided by a Third Party Administrator such as RWHC. RWHC would be in a position to provide final statistic analysis and recommendations as to how Network and its members can compete more aggressively in the market by providing health care services at a cost lower than other competitors.

18. The Nature, Type, Timeliness and Specificity of the Information to be Obtained.

The information to be obtained would take into account information concerning utilization, quality standards, cost to purchase services on a corporate and individual basis, fees, charges and clinical outcomes. This material would be handled by a Third Party Administrator. For purposes of this letter, we assume that the Cooperative will be the Third Party Administrator.

19. The Method by Which Information Will be Exchanged.

See answers to questions 8, 16, 17 and 18 above.

20. The Characteristics of the Market.

We are assuming that there are a series of individual, discrete geographic markets for the products under discussion. These geographic markets correspond with the market areas of individual rural hospitals. There is increasingly enhanced competition from tertiary care centers which are seeking to achieve additional market penetration as market shares arising from competition between managed care entities mature. Large integrated health care delivery systems are likewise attempting to penetrate and control various segments of the aggregate geographical area formed by contiguous discrete rural hospital markets. (See Attachment 1)

21. The Identity and Competitive Significance of Persons That Participate in the Relevant Market But Will Not Participate in the Information Exchange.

The only parties that would participate in an information exchange would do so in accordance with the restrictions set forth previously in this letter. These parties would consist of only those rural hospitals participating in Network. No other parties would share in any information exchange.

22. The Ten Largest Customers in Any Market That Will be Involved in the Exchange of Information.

No specific companies or customers have been identified by the proposed Network.

23. Describe All Safeguards That are Planned to Prevent Disclosure of Specific Information to Competitors.

Insofar as it is concluded that particular hospitals may be competitors, we are prepared to have a Third Party Administrator create a data base, prepare statistical analyses and furnish recommendations in a confidential fashion. Except for the final statistical analysis and recommendations, no member shall have access to any disaggregated information held by the Third Party Administrator or any accounting firm, actuary or research firms providing services. It is anticipated that the RWHC Network would establish rules and regulations prohibiting the disclosure of information to competitors. By the terms of the proposed bylaws, all members must abide by the rules and regulations. Furthermore, no member shall have access to another member's patient fee or pricing information.

Very truly yours,

QUARLES & BRADY

Michael S. Weiden

cc: David C. Jordan, Assistant Chief
U.S. Department of Justice